GEORGIA SKIN CANCER
& Aesthetic Dermatology

CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

In order for us to treat a minor without a parent/legal guardian present, please complete this form and return it with a copy of the parent/legal guardian's drivers license to Georgia Skin Cancer & Aesthetic Dermatology.

I, _____ (print name here), certify that I am the parent/legal guardian of _____ (print name of minor), currently a minor, and whose date of birth is _____. And, as such, I hereby authorize Georgia Skin Cancer & Aesthetic Dermatology to provide medical care to my son/daughter, including but not limited to: diagnostic examination (including laboratory testing), treatment procedures, and prescribing of medication as deemed appropriate by his/her physician or practitioner. I understand that, should my child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated. I further understand that, once my child reaches the age of 18, my consent for treatments is no longer required. This consent will remain in effect until the patient reaches eighteen years of age, unless revoked in writing to Georgia Skin Cancer & Aesthetic Dermatology. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period. By signing this, I acknowledge I have read and agreed to this consent and that any questions I had prior to signing were answered by Georgia Skin Cancer & Aesthetic Dermatology.

_____ _____

(Signature of Parent/Legal Guardian) (Relationship to Patient)

_____ _____

(Best Contact Phone Number) (Date of Signature)

Revised 9-9-2021